

NEW YORK STATE COMMISSION OF CORRECTION

In the Matter of the Death

of Rashad McNulty, an inmate of
the Westchester County
Correctional Facility

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FINAL REPORT OF THE
NEW YORK STATE COMMISSION
OF CORRECTION

TO: Commissioner Kevin Cherverko
Westchester County Department of Correction
PO Box 10
Valhalla, New York 10595

GREETINGS:

WHEREAS, the Medical Review Board has reported to the NYS Commission of Correction pursuant to Correction Law, section 47(1)(d), regarding the death of Rashad McNulty who died on January 29, 2013, while an inmate in the custody of the Westchester County Department of Correction, the Commission has determined that the following final report be issued.

FINDINGS:

1. Rashad McNulty was a 36-year-old black male who died on 1/29/13, at 6:16 a.m. from Stenosing Coronary Arteriosclerosis while in the custody of the Westchester County Department of Correction. McNulty's complaints of chest pain were mismanaged by nursing staff from New York Correct Care Solutions (NYCCS) Inc., resulting in a 90 minute delay in receiving physician ordered treatment. The physician, also employed by NYCCS Inc., made a hazardous presumptive diagnosis of abdominal distress on McNulty, a patient presenting with accepted symptoms of acute coronary syndrome, without the benefit of actually examining McNulty or performing requisite diagnostic tests. While being returned to his housing unit at 4:25 a.m., McNulty complained of feeling dizzy and was unable to ambulate. Nursing staff failed to take appropriate action and abandoned McNulty by placing him in his cell and not returning him to the medical clinic or having him emergently transported to a hospital. At 5:06 a.m., McNulty was found in his cell unresponsive and in cardiac arrest. Had McNulty been given appropriate emergency medical care and sent to a hospital in a timely manner his death may have been prevented.

2.

[REDACTED] In the instant offense, McNulty was remanded to the custody of the Westchester County Department of Correction as a federal custody inmate on 8/9/11.

3.

4.

[REDACTED] Westchester County CF's customary procedure for new admissions is to

complete a Mental Health Referral automatically regardless of incoming inmate's Suicide Screen score.

5.

[REDACTED]

6.

[REDACTED]

7.

[REDACTED]

8.

On 1/25/13, at approximately 4:31 p.m., McNulty was involved in an altercation with two other inmates. When the officers responded, they observed McNulty on the floor defenseless while two other inmates were punching and kicking him. The officers intervened immediately.

[REDACTED]

[REDACTED] Due to fact that McNulty had previous incidents which were reported to be gang related, corrections staff made a decision to place McNulty in protective custody housing. McNulty refused to be transferred and was given a disciplinary ticket. He was then placed in OJ -C- 3 West; cell #5 which was a protective custody unit.

9.

On 1/29/13 at approximately 1:50 a.m., Officer K.G. was conducting a supervisory round and was notified by McNulty that he had chest pain. LPN D.J. received a telephone call at the Old Jail Clinic medical clinic regarding an inmate who was complaining of chest pain. LPN D.J. reported the charge nurse, RN P.S. was not in the medical clinic area, and she referred the telephone call to RN J.B., the booking RN. Officer K.G. also stated he notified the booking nurse, RN J.B. RN J.B. instructed Officer K.G. to send McNulty to the booking admission area which had a medical examination room. Captain F.D. stated that Officer K. G. also notified him about McNulty's chest pain. RN J.B. was the assigned booking nurse responsible for obtaining initial medical information from the inmates who were entering the Westchester County CF and administrating inmates' medications before they were transported to court. McNulty was escorted by Officer A.S. to the booking area; arriving at 2:12 a.m.

10.

While in the booking area, Officer A.S. reported that McNulty was in a state of panic, nervousness, and constantly shifting in his chair.

[REDACTED]

11.

[REDACTED]

The Medical Review Board opines that Dr. R.U. made a dangerous presumptive diagnosis of abdominal distress based only a phone report from a nurse and failed to order any other requisite diagnostic tests or request immediate transport to a hospital to rule out acute coronary syndrome. [REDACTED]

[REDACTED]

Had McNulty been immediately transported to a hospital and received percutaneous cardiac intervention, his death may have been prevented.

12. While McNulty was still in the booking area, RN J.B. instructed Officer A.S. to escort him down to the Old Jail Medical Clinic to received medication [REDACTED]. This was done because the customary practice is that no medications are kept in the Booking medical area. RN J.B. then told Officer A.S., after the administration of the medications, to return McNulty to the booking area for further observation. At 2:40 p.m., Officer A.S. escorted McNulty to the Old Jail Clinic.
13. On 1/29/13 at 2:35 a.m., RN P.S. reported she was in the Old Jail Clinic triaging sick call slips on her break. RN P.S. reported she received a telephone call from RN J.B. requesting that she medicate McNulty, and he was enroute for the [REDACTED]. RN P.S. reported she would not administer McNulty the medications [REDACTED] as it was the responsibility of RN J.B. to do so since he received the verbal order from the physician orders and they were not presently transcribed in McNulty's computerized medical record. This necessitated RN J.B. to administer the medications himself. These medications orders were not produced to the Commission by the jail or the medical vendor, NYCCS Inc. at the time of the investigation. RN P.S. reported she received a telephone call from an unidentified officer who stated that the inmate was on his way to the Old Jail Clinic. RN P.S. called RN J.B. and instructed him to report to the Old Jail Clinic from the Booking Nursing Area to administer the [REDACTED] to McNulty. RN J.B. stated he was putting the order in the computer but would be up to administer the medications.
14. At 2:40 a.m., McNulty arrived at the Old Jail Clinic. RN P.S. reported she observed McNulty moaning in pain upon arrival. RN P.S. reported she obtained McNulty's name and reviewed his chart. McNulty was observed by RN P.S. pacing around and requesting to lie down but could not due to his handcuffs being tight. Officer A.S. also reported that McNulty, while

waiting for RN J. B. to arrive, requested to lie down. Officer A.S. did loosen the cuffs for McNulty and helped him onto an exam table. Officer A.S. stated that RN P.S. did not move from the chair that she was sitting in behind the nurses' desk.

15. LPN D.J. reported she was returning from relieving another nurse from a break when she observed McNulty sitting in the Old Jail Clinic with an officer. [REDACTED]

16. At 3:17 a.m., RN J.B. arrived at the Old Jail Clinic to administer the medications [REDACTED] approximately 40 minutes after obtaining the telephone order from Dr. R.U. RN J.B. and Officer A.S. then escorted McNulty back to a holding cell at the booking area at 3:24 a.m. At approximately 4:00 a.m., while in the booking area, McNulty stated he felt a little better. RN J.B. reported that he called RN P.S. to confer with her. [REDACTED]

[REDACTED] The emergency medical care provided to McNulty by the nursing staff from NYCCS Inc. was grossly uncoordinated and mismanaged. McNulty was moved between two separate locations for the purposes of assessment and treatment causing unnecessary delay. McNulty's signs and symptoms, all highly indicative of acute coronary syndrome, were dismissed by nursing staff. RN J.B. also failed to adequately monitor McNulty as ordered by the physician by failing to re-assess McNulty's vital signs after administering medications.

17. On 1/29/13 at approximately 4:22 a.m., McNulty was escorted back to his housing unit by Officers A.S. and D.M. Officer A.S. stated that McNulty did not complain of any chest pain on the way to his housing unit (3-West). When McNulty arrived at 3-West, he stated he was feeling dizzy to the escort officers. He was observed by Officer K.G. to be unsteady while standing and leaned on the wall outside the housing unit. Officers A.S. and D.M. assisted McNulty to the floor as he was very unsteady and appeared to be starting to fall.

18. At approximately 4:25 a.m., Officer K.G. called a Signal 3 medical emergency. RN J. B., RN P.S. and LPN D.J. retrieved emergency equipment and responded to the scene. Captain F.D. also responded and stated he observed McNulty lying face down in an area outside his housing unit. The officers placed McNulty on his side. When RN P.S. arrived she told McNulty to stand up, but he did not respond. Captain F.D. stated that RN P.S. told McNulty to "get up and walk" but McNulty could not. The captain also stated that RN P.S. pulled on McNulty's arm several times. McNulty was sweating from his forehead, was pale, and was described as "dazed." Officer A.S. reported that LPN D.J. used a smelling salt under McNulty's nose which he responded to. [REDACTED]

[REDACTED] RN P.S. stated to Officers K.G., A.S., Captain F.D., and RN J.B. "let's take him down to the clinic." RN P.S. told McNulty that he was going to the medical clinic and to get up and get in the wheelchair. McNulty got up from the floor and sat in the wheelchair. Officers K.G., A.S., Captain F.D., and RN J.B. all documented that RN P.S. stated "that's the oldest trick in the book" and "I've been doing this too long to be fooled". RN P.S. then told McNulty he would be going back to his cell. RN J.B. stated that

McNulty said he "didn't want to die." Officer A.S. stated that McNulty requested to see a doctor. McNulty stated he needed to use the toilet and was moved to the housing unit by the wheelchair. McNulty got up from the wheelchair with assistance and then ambulated to the toilet in his cell. RN P.S. told Officer K.G. that she would be back later to check on McNulty. All responding staff left the block at 4:31 a.m. Both RN J.B. and P.S. committed professional misconduct by failing to take appropriate action, failing to maintain a proper medical record, and abandoning a patient who was in obvious distress.

19. According to the New York Correct Care Solutions Policy J-G-03 entitled Infirmary and Medical (MH) Observation Unit, (9) states:

"Observation Patients may be placed by a qualified health care professional other than a physician; however, a physician's order is needed to keep them longer than 24 hours."

Dr. R.U. stated to Commission staff during the investigation that nurses are considered to be qualified health care professionals referenced in this policy. Nurses are permitted to place inmates in the infirmary if they determine the patient needs further observation but this was not considered for McNulty.

20. According to video recording of unit 3-West, Officer K.G. went to McNulty's cell several times. The officer went to McNulty's cell at 4:36 a.m., 4:41 a.m., and 4:42 a.m. At approximately 4:45 a.m., Officer K.G. went back to McNulty's cell and observed McNulty sitting on the toilet. Officer K.G. asked McNulty how he was feeling, and McNulty responded that he "never felt like this before." At 4:50 a.m., Officer K.G. heard moaning from the C-side of the tier and the inmates calling for an officer. Officer K.G. went down the corridor to check on McNulty who was lying on his bed. Officer K.G. reported that he asked McNulty how he was feeling to which McNulty responded that he was in pain. At 4:55 a.m., Officer K.G. went down the tier corridor to check on McNulty and observed him sitting on the toilet.
21. On 1/29/13, at 5:00 a.m., Officer K.G. completed a supervisory tour and observed McNulty lying on his bunk moaning. Officer K.G. then stated he called McNulty's name three times in which he received no response. Officer K.G. reported that McNulty was breathing at this time and called RN P.S. and Captain F.D. by telephone. While in the Old Jail clinic, RN P.S. told LPN D.J. she would be going to the tier to see McNulty. Officer K. G. stated that RN P.S. arrived almost immediately.
22. RN P.S. arrived at McNulty's cell at approximately 5:01 a.m. Officer K. G. and RN P.S. looked in McNulty's cell several times with the lights off. RN P.S. requested the tier lights to be turned on, which occurred at approximately 5:06 a.m. At that time, RN P.S. and Officer K. G. entered McNulty's cell and found McNulty lying on his bed unresponsive with no vital signs. RN P.S. instructed Officer K.G. to call a Code 3. RN P.S. then reported she started CPR. Officer K.G. stated he immediately ran down the tier corridor and called in the code to Central Control. Officer K.G. then went back to McNulty's cell where RN P.S. asked Officer K.G. for assistance in moving McNulty to the floor with his mattress. [REDACTED]
- [REDACTED]

23.



24.

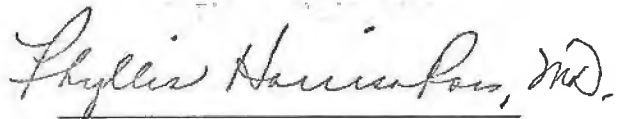
RECOMMENDATIONS:TO THE CHIEF EXECUTIVE OFFICER OF NY CORRECT CARE SOLUTIONS:

1. The Chief Executive Officer shall direct a quality assurance review be conducted with nursing staff to assure that transcription of verbal physician orders is conducted in a timely manner.
2. The Chief Executive Officer shall direct a quality assurance review be conducted with nursing staff to assure that when there is deterioration in a patient's medical condition the on-call physician is immediately informed.
3. The Chief Executive Officer shall direct a quality assurance review be conducted with nursing staff to assure essential patient information with emergency events, e.g. vital signs is properly documented.
4. The Chief Executive Officer shall direct a quality assurance review be conducted with nursing staff regarding the observation of the medical symptomology in which a patient's admission for observation to infirmary is warranted.
5. The Chief Executive Officer shall direct a quality assurance review be conducted with nursing staff to assure thorough nursing assessments including vital signs are completed before releasing patients from medical observation.
6. The Chief Executive Officer shall commence a comprehensive review and revision of all emergency sick call procedures.
7. The Chief Executive Officer shall provide a report to the Medical Review Board on all quality assurance reviews and any corrective action plans taken.

TO THE NYS DEPARTMENT OF EDUCATION, OFFICE OF PROFESSIONAL CONDUCT (OPD):

1. An investigation be conducted for professional misconduct of Registered Nurse P.S. and Registered Nurse J.B. of New York Correct Care Solutions Inc. for practicing with gross incompetence by failing to recognize obvious cardiac symptoms in the course of nursing care of Rashad McNulty, failing to maintain proper medical records, and for abandoning a patient in obvious distress.

WITNESS, HONORABLE PHYLLIS HARRISON-ROSS, M.D., Commissioner, NYS Commission of Correction, 80 South Swan Street, 12th Floor, in the City of Albany, New York 12210 this 16th day of June, 2015.



Phyllis Harrison-Ross, M.D.
Commissioner

PH-JJ:ams
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Cc: Dean Rieger, MD MPH
Chief Executive Officer
New York Correct Care Solutions Medical Services, P.C.